SERFF Tracking Number:	*CAIC-128418778*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*8653*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness C20000*		
Project Name/Number:	*Revised Critical Illness Enrollment Form/*		

Filing at a Glance

Company: Continental American Insurance Company

Product Name: Critical Illness C20000	SERFF Tr Num: CAIC-128418778	State: Arkansas
TOI: H07G Group Health - Specified Disease - Limited Benefit	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H07G.001 Critical Illness	Co Tr Num: 8653	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Sara McCormick	Disposition Date: 05/30/2012
	Date Submitted: 05/29/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Revised Critical Illness Enrollment Form	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer, Other	Explanation for Other Group Market Type: Union
Overall Rate Impact:	Filing Status Changed: 05/30/2012
	State Status Changed: 05/30/2012
Deemer Date:	Created By: Sara McCormick
Submitted By: Sara McCormick	Corresponding Filing Tracking Number:

Filing Description:

This enrollment form is being filed for your review and approval. This is a new filing and will not replace any other forms on file with your department.

The enrollment form will be used with our previously approved Group Critical Illness products, series C20100AR et al. and series CAI2800AR, et al.

If you have any questions or require additional information, please contact Sara McCormick either at 1.888.730.2244,

ext. 5942 or at companycompliance@aflac.com. Thank you for your consideration in this matter.

Sincerely,

James J. Hennessy, AIRC, CCP
Vice President, Compliance
/scm
State Narrative:

Company and Contact

Filing Contact Information

Marsha Tate, Analyst	MTate@caicworksite.com
2801 Devine Street	803-461-4478 [Phone]
Columbia, SC 29205	

Filing Company Information

Continental American Insurance Company	CoCode: 71730	State of Domicile: South Carolina
2801 Devine Street	Group Code:	Company Type: LAH
Columbia, SC 29205	Group Name: Continental Amer Ins Co	State ID Number:
(803) 256-6265 ext. [Phone]	FEIN Number: 57-0514130	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	South Carolina's retaliatory fee is zero dollars; therefore, we are submitting the following: 1 application x $50.00 = $50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	$50.00	05/29/2012	59459813

SERFF Tracking Number:	*CAIC-128418778*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*8653*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness C20000*		
Project Name/Number:	*Revised Critical Illness Enrollment Form/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/30/2012	05/30/2012

SERFF Tracking Number:	*CAIC-128418778*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*8653*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness C20000*		
Project Name/Number:	*Revised Critical Illness Enrollment Form/*		

Disposition

Disposition Date: 05/30/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CAIC-128418778*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*8653*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness C20000*		
Project Name/Number:	*Revised Critical Illness Enrollment Form/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number:	*CAIC-128418778*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*8653*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Critical Illness C20000*		
Project Name/Number:	*Revised Critical Illness Enrollment Form/*		

Form Schedule

Lead Form Number: C20207

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/30/2012	C20207	Application/ Enrollment Form	Enrollment Form	Initial		0.000	C20207 Enrollment Form.pdf

[Aflac]

CONTINENTAL AMERICAN INSURANCE COMPANY

ENROLLMENT FORM

Please Mail To: Post Office Box 427
Columbia, South Carolina 29202
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Critical Illness		

Endorsement:

EFFECTIVE DATE:

FOR AGENT USE ONLY			
☐ **Initial Enrollment**	☐ **New Hire**	☐ **Re-Enrollment**	☐ **Newly Eligible**

Deduction start date _____

[Employee] Name/Certificate Holder (First, MI, Last)	**Social Security Number/ID Number**	**Gender**	**Date of Birth**
Street Address	**City**	**State**	**ZIP**

[Employer]	**Job Class/Occupation**	**Location**	**Hire Date/Change of Status Date**

Hours Worked	**Daytime Phone Number ( )**	**Beneficiary Name/Relationship (estate unless designated otherwise)**

Spouse's Name (if coverage is requested)	**Gender**	**Spouse's Date of Birth**

	[Employee]	**Spouse**
[Are you currently working [part-time;full-time] for the [employer] listed above?]	☐ **YES** ☐ **NO**	
[Are you now disabled or unable to work?]		☐ **YES** ☐ **NO**
[Have you used tobacco products in the last 12 months?]	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

CRITICAL ILLNESS [☐ [Employee]] [☐ [Employee] and Spouse]] [Section 125: ☐ Yes ☐ No] [With Cancer: ☐ Yes ☐ No]

[☐ New Coverage] [☐ Change in Coverage]

[Employee] Face Amount: $_____ [**Employee] cost per pay period:** $_____

[☐ Automatic Increase Rider] [☐ Dependent Child Benefit Rider] [☐ Heart Event Rider]

[☐ Specified Critical Illness Rider] [☐ Genetic Screening Test Rider]

Spouse Face Amount: $_____ **Spouse cost per pay period:** $_____

[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of [$x.xx].]

		[Employee]	**Spouse**
[1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
3	Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) high blood pressure, resulting in your now taking 3 or more medications for treatment?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
[4	Have you ever received any advice, treatment, or consultation for: any disorder of the central nervous system, Parkinson's Disease, Alzheimer's Disease, dementia, senility, or organic brain syndrome?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO]**
[[5]	In the last 2 years, have you had a prolonged state of unconsciousness lasting more than 48 hours or that left you with a significant neurological disability?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO]**
[All applicants enrolling in coverage over [$50,000] in Employee benefits MUST answer the following additional questions:			
[[6]	Height/Weight	**ft in lbs**	**ft in lbs]**

This application is not complete unless signed and dated as indicated.

[[7]	Have you been advised to have any diagnostic test, hospitalization, surgery, or treatment that has not yet been completed?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO]**
[[8]	In the past two years, have you had a systolic blood pressure reading of 150 or above or a diastolic blood pressure reading of 100 or above?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO]**
[[9]	Have you had an annual physical examination in the last [6 months]? If yes, provide name and address of physician and date of exam. _____ _____	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO]]**

Does this coverage replace or change any existing insurance? ☐ **YES** ☐ **NO**

If yes, provide carrier and policy number: _____

[If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.]

Coverage will not become effective unless you are employed [part-time; full-time] on the enrollment date and on the effective date.

CERTIFICATION: I have read the completed Application and I realize any false statement or misrepresentation in the Application may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Application is approved and the necessary premium is paid.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

[I authorize [my employer] to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.]

[I certify that I currently work [part-time; full-time] for the [employer] listed on this application [and that my spouse is not currently disabled or unable to work]. [I further certify that neither my spouse nor I have used tobacco products in the last 12 months.]]

A person is guilty of insurance fraud if he intends to defraud an insurer or if he knowingly facilitates a fraud against an insurer. Fraudulent activities include submitting an Application or filing a claim that contains any false or deceptive statement.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____Agent No._____ State of Enrollment_____

Things to Consider Before Replacing Your Existing Insurance Coverage

Aflac's goal is to provide you with outstanding insurance products that offer important financial protection to you and your loved ones in the event of an accident or illness. To best serve our customers, we offer a robust portfolio of products designed to respond to a variety of needs and circumstances. If you are thinking about replacing one type of policy for another, please be aware that there are important differences between insurance products—specifically group products versus individual products. These differences may affect your coverage. Before making a change to any existing coverage you may have, please make sure to carefully compare the benefits provided by your existing policy and the proposed replacement coverage. Among the items you should consider are the following:

1. If you are currently receiving treatment for an injury or illness: Your new coverage will not cover claims for treatment received as a result of injuries or illnesses diagnosed prior to its effective date.
2. If you terminate existing coverage, no benefits will be paid for diagnoses or treatments you receive after the termination date.
3. Benefits of your existing policy and the replacement coverage you're considering may be different, and you may be subject to new waiting periods and/or coverage exclusions due to preexisting conditions.
4. If you terminate an existing policy, you will lose any accrued benefits. Any such accrued benefits cannot be transferred to new coverage.
5. Individual insurance coverage is guaranteed-renewable and cannot be cancelled for any reason other than non-payment of premium.
6. Group insurance coverage is not guaranteed-renewable. If the master policy held by your employer or organization is cancelled, your coverage terminates.
7. Individual insurance coverage is fully portable. If you leave your current job, you can retain your individual insurance coverage.
8. Group coverage has limited portability. If you change jobs, you may not be able to retain your coverage.

By signing below, I acknowledge that I have received this notice and wish to apply for new coverage.

Signature of Applicant_____ Date_____

Applicant's Name (printed)_____

Address (printed)_____

E-Mail Address_____ Telephone_____]

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Project Name/Number:	*Revised Critical Illness Enrollment Form/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/30/2012

Comments:

Our Group Critical Illness products, series C20000 and CAI2800, were previously approved by your department with a Flesch Reading Score which exceeded your minimum requirement of 40. This enrollment form is intended to be used with those forms.

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	05/30/2012

Comments:

This filing is solely for an application form.